

§ 417.592(b)(2), CMS reduces the amount of payment by the appropriate amount.

(e) *Determination of rate for calendar year 1998.* For calendar year 1998, HMOs or CMPs with risk contracts will be paid in accordance with principles contained in subpart F of part 422 of this chapter.

[50 FR 1346, Jan. 10, 1985; 50 FR 20570, May 17, 1985, as amended at 52 FR 8901, Mar. 20, 1987; 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995; 63 FR 35067, June 26, 1998]

§ 417.585 Special rules: Hospice care.

(a) No payment is made to an HMO or CMP on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

(b) During the time the election is in effect, the HMO or CMP may bill CMS on a fee-for-service basis (subject to the usual Medicare rules of payment) but only for the following covered Medicare services:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the HMO or CMP and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which the enrollee elected hospice care or a condition related to the terminal condition.

(3) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

(c) Payment for hospice care services furnished to Medicare enrollees of an HMO or CMP is made to the Medicare-participating hospice elected by the enrollee.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38082, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.588 Computation of adjusted average per capita cost (AAPCC).

(a) *Basic data.* In computing the AAPCC, CMS uses the U.S. per capita incurred cost and adjusts it by the factors specified in paragraph (c) of this section to establish an AAPCC for each class of Medicare enrollees.

(b) *Advance notice to the HMO or CMP.* Before the beginning of a contract period, CMS informs the HMO or CMP of the specific adjustment factors it will use in computing the AAPCC.

(c) *Adjustment factors—(1) Geographic.* CMS makes an adjustment to reflect the relative level of Medicare expenditures for beneficiaries who reside in the HMO's or CMP's geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the HMO's or CMP's geographic area and that is available to CMS when it makes the determination.

(2) *Enrollment.* CMS makes a further adjustment to remove the cost effect of all area Medicare beneficiaries who are enrolled in the HMO or CMP or another HMO or CMP.

(3) *Age, sex, and disability status.* CMS makes adjustments to reflect the age and sex distribution and the disability status of the HMO's or CMP's enrollees based on Medicare program experience and available data that indicate cost differences that result from those factors.

(4) *Other relevant factors.* If accurate data are available and appropriate, CMS makes adjustments to reflect welfare and institutional status and other relevant factors.

[50 FR 1346, Jan. 10, 1985, as amended at 58 FR 38083, July 15, 1993; 60 FR 46232, Sept. 6, 1995]

§ 417.590 Computation of the average of the per capita rates of payment.

(a) *Computation by the HMO or CMP.* As indicated in § 417.584(b), before an HMO's or CMP's contract period begins, CMS determines a per capita rate of payment for each class of the HMO's or CMP's Medicare enrollees. In order to determine the additional benefits required under § 417.592, weighted averages of those per capita rates must be